Universal Pharmacy Medical Review Request Form

TUFTS Health Plan

www.tuftshealthplan.com/providers
Provider Services - 888-884-2404
Precertification Department (FAX) - 617-972-9409

Only complete forms can be processed. Incomplete forms may result in an administrative denial due to lack of information

PATIENT INFORMATION

Name: ______________________________ Date: ________________

DOB: _____________ Member THP ID: __________________________

Diagnosis: ____

Relevant Co-morbid Diagnoses: _________________________________

Additional Comments:

____

____

REQUESTED DRUG INFORMATION

Type of Program Override Request (check one):

____ Dispensing Limitation ____ Non-covered Drug
____ Step Therapy ____ Prior Authorization

Drug Name/Strength/Dosage Form: ______________________________

Duration of requested treatment: _________________________________

Reason for Coverage Request (check one):

______ Treatment failure (drug(s)): _________________________________

______ Adverse reaction (drug(s)): _________________________________

______ Other clinical reason(s): ___________________________________

Duration of treatment with failed drug(s): ____________________________

Aranesp, Epogen, Procrit (Tufts Health Plan Medicare Preferred ONLY)

Is this being used to treat anemia in a patient with chronic renal failure that undergoes dialysis ___ Yes ___ No

Fax/Mail completed forms to: Tufts Health Plan Precertification Department, 705 Mount Auburn Street, Watertown, MA 02472
Fax: (617) 972-9409

PRESCRIBER INFORMATION

Name: ________________________ Specialty: ___________________

Provider ID: ___________________ Phone: _______________________

Fax: _________________ Office Contact: _________________________

Prescriber Signature (required): _________________________________

Tier exception request (Tufts Medicare Preferred ONLY): ___Yes ___ No

Please specify reason(s) for request:

_____ Formulary/Preferred drug(s) contraindicated or tried and failed, or not as effective as requested drug

_____ Therapeutic failure or not as effective; please indicated length of therapy of each applicable drug and adverse outcome

_____ Other; please explain below

Explanation:____

____

Antifungals (itraconazole (Sporanox), Penlac, terbinafine (Lamisil), etc.)

Does the patient have uncomplicated onychomycosis? ____Yes* _____ No

1. Limited to nail surface? ___Yes ___ No
2. Lunular involvement? ___ Yes ___ No
3. Does the patient have a medical contraindication to oral antifungal therapy (**Penlac only**): ___Yes (explain)______________________ No ___
4. Check all that apply:

   ____ Paronychia ____ Diabetes Mellitus
   ____ Systemic Fungus ____ Immune Suppression
   ____ Peripheral Vascular Disease ____ None
   ____ Medically significant pain (Office notes required)

* Any request for coverage with a diagnosis of uncomplicated onychomycosis will be denied as a benefit exclusion

Drug List and Clinical Criteria available online at: www.tuftshealthplan.com